

## SUD Leaders Discuss Covid-19 Public Health Emergency

*"I just want to say that it's been really interesting to hear what other states are experiencing. Our experience has been very similar with COVID in our office."*

–Brent Kelsey, Utah Department of Substance Abuse and Mental Health

The Mountain Plains Addiction Technology Transfer Center (ATTC) hosts a 32-member Advisory Board (Board) that provides valued guidance and expertise to the ATTC Co-Directors, Nancy Roget and Thomasine Heitkamp. The Board is composed of accomplished experts in the field of substance use disorders (SUD) representing each of the six states in the Mountain Plains region: Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming. The Board provides a critical voice to the direction of the Mountain Plains ATTC through their capacity as opinion leaders and experts in SUD treatment and recovery support services.

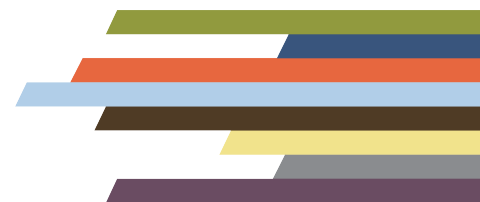
*The focus of the ATTCs, which are funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), is to:*

1. Accelerate the adoption and implementation of evidence-based and promising addiction treatment and recovery-oriented practices and services,
2. Heighten the awareness, knowledge, and skills of the workforce that addresses the needs of people with substance use or other behavioral health disorders, and
3. Foster regional and national alliances among culturally diverse practitioners, researchers, policy makers, funders, and the recovery community.<sup>1</sup>

The Mountain Plains ATTC hosted its semi-annual Advisory Board meeting on September 16, 2020. The purpose of the meeting was to provide brief updates on the ATTC's progress since the March 2020 meeting, assess training and technical assistance needs, and determine perceptions regarding the impact of the COVID-19 Public Health Emergency (PHE). To facilitate

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<sup>1</sup> <https://attcnetwork.org/centers/global-attc/about-attc-network>



the discussion phase of the meeting, Board members had the opportunity to respond to the following questions provided in the meeting agenda shared prior to the meeting:

*What are you seeing as the impact of COVID-19 on your current operations?  
How can the Mountain Plains ATTC support you?*

Co-Directors Roget and Heitkamp facilitated the discussion, with a focus on determining how the Mountain Plains ATTC can assist the workforce in Region 8 as the country enters the seventh month of the COVID-19 PHE. All Board members indicated that they have gained a wealth of experience regarding the difficulties of serving patients and consumers during the current PHE. Their experience provides lessons learned for the present and future planning for the Mountain Plains ATTC as outlined in this summary.

The September 16<sup>th</sup> virtual meeting, conducted on the Zoom platform, was recorded<sup>2</sup> and transcribed to assist in preparing meeting minutes. Prior to distribution of the minutes, the individual transcribed statements were forwarded to each Board member with a request for corrections and approval for inclusion in the final minutes. In addition, Co-Directors Heitkamp and Roget forwarded an individual email requesting written comments from members who did not have the opportunity to speak due to a rush for time at the end of the meeting and some members needing to leave the meeting early. One member chose to forward written comments.

Co-Director Heitkamp prepared the content below from the comments in the meeting notes. This content includes a rich narrative of the depth and breadth of experiences that Board members have gained in their administrative and supervisory capacities while adapting to challenges related to the PHE.

## **Six Themes Identified**

*The themes from the discussion session included:*

1. Concerns for the safety and well-being of patients;
2. Concerns for the safety and well-being of staff;
3. Unique stressors of in-patient treatment facilities;
4. Importance of communications and supports;
5. Telehealth response: Advantages and disadvantages; and
6. Opportunities to re-examine delivery of services.

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<sup>2</sup> Board members had the opportunity to opt-out of recording the meeting, with no one making this request.

## Concerns for the Safety and Well-being of Patients

In this theme, comments focused on the need to support patients and ensure access to treatment and recovery support services.

*“Our biggest concern is the impact of COVID on our patient population, our staff, folks out there who are in recovery and people who are struggling and haven’t found us. We’re seeing more unemployed and homeless, and they are reporting more impactful use.”*

–Kurt Snyder, Heartview Foundation

Several Board members described the importance of being responsive to the needs of persons at greatest risk during the PHE, including people living in poverty, people who are unemployed, and persons who are homeless. Patients requiring ongoing support include persons with complex co-occurring and co-morbid disorders, young adults who are emancipating, people in recovery, and persons with disabilities who are at greater risk during a PHE.

*“The pandemic has impacted people with disabilities in nearly every aspect of life. The way the world has adapted to the pandemic often creates new barriers for PWD that didn’t exist before. It’s an extremely delicate dance between upholding the rights of PWD and ensuring public health and safety.”*

–Emily Shuman, Rocky Mountain ADA Center

It was noted that the PHE is posing unique challenges for people in recovery. This necessitates the use of new online/virtual approaches to providing ongoing support, as well as offering Peer Recovery Specialist training. There is also a higher risk of use during the PHE that could result in overdose. Due to COVID restrictions at hospitals, staff are not allowed in emergency departments but have set up new communication protocols with ED staff to receive contact information for patients seeking follow-up counseling and recovery support services.

Finally, Board members described the stress on patients due to changes required in offering services in a virtual environment. For example, two Board members noted those they serve are missing participation in group therapy on a face-to-face basis.

*“We’ve been very fortunate with good attendance in the virtual groups, but there is still something about being able to be face-to-face with other human beings.”*

–Amy Hartman, Volunteers of America, Dakotas

## Concerns for the Safety and Well-being of Staff

Concerns about employees’ well-being were noteworthy among many Board members as most

if not all staff are working remotely. Adjustments are being made to accommodate workforce issues, including training staff on using telehealth technologies to deliver services. A Board member from Wyoming shared that they are using Zoom to conduct daily 'check-in' meetings with staff, primarily to monitor how staff are coping emotionally. Using technology to stay connected with staff and patients is beginning to normalize this new way to communicate.

*"We, also, are seeing a lot of providers pivoting."*

–Gen Berry, WICHE

Demands for increased flexibility in service delivery have increased stress for many providers. Terms used to describe these concerns included burnout and COVID fatigue. In addition, the importance of remaining vigilant to stop the spread of Covid-19 was identified as an added pressure on staff, which can become more problematic relative to job performance when employees are overwhelmed. Comments about the lack of capacity to view an "end in sight" to the PHE reflects the perceptions of COVID fatigue.

*"We are really starting to get to a point where we're just surviving—thinking that there's a light at the end of the tunnel, but that light keeps getting farther and farther away."*

–Kurt Snyder, Heartview Foundation

*Board members mentioned stressors on behavioral health providers which are a direct result of the PHE, including:*

1. School closures requiring changes in staffing patterns and increased caretaking demands in the home among staff;
2. Requirements that staff adapt to the use of telehealth;
3. An increase in demands for services;
4. The need to quarantine due to exposure or infection; and
5. The stress of maintaining therapeutic distance.

*“There’s another level of complexity, that maybe others have considered, and that is the therapist –on a day-to-day basis, [is also] dealing directly with COVID related issues - as is the patient. The ability to maintain therapeutic distance is getting smaller, and I’m concerned that it’s weighing very heavily on our clinical staff.”*

–Lisa Gawenus, Denver Health

Of note were concerns about front-line staff who work for minimal pay serving people in shelters and group homes during a PHE, suggesting the need to provide support for these staff.

One Board member noted problems with recruitment and retention of staff. In response, an agency created a recruitment and retention taskforce that includes adapting best practices to reward staff – especially the front-line staff.

*“Our providers are really struggling with all the added stress of more and more people seeking help. It just doesn’t seem to end!”*

–Mary Windecker, Behavioral Health Alliance of Montana

Underscoring the concerns regarding retention is the importance of assuring that staff who are at greatest risk, including older adults, are safe in the workplace.

*“One staff member unexpectedly decided to take early retirement.”*

–Dan Krause, Boyd Andrew Community Services

The burden on administrators and supervisors of SUD services was evident in their concerns for the safety and well-being of staff. Their fears that a workforce, which is already stressed, will be “stretched even thinner”. One member noted there are few applicants for a current open position.

## **Unique Stressors on In-Patient Treatment Facilities**

*“To respect safe distancing, we are only accepting patients at half capacity at both facilities.”*

–Karen Severns, Great Plains Area Indian Health Services

The PHE poses distinct challenges for in-patient treatment facilities. First, having patients in a residential setting requires staff to use personal protective equipment (PPE). The shortage of PPE is not limited to hospitals, as noted by a Board member that Montana residential facilities have ‘frantically’ searched for PPE.

Next, facilities throughout the six states have downsized their capacity in treatment facilities to ensure adherence to guidelines of physical distancing. For example, Utah residential treatment beds have been reduced from four per room to two, and new admissions are limited to detox. In South Dakota, residential facilities (especially those with women's programs) are reducing capacity to allow for potential flexibility in the event that incoming patients need to be quarantined. This downsizing of in-patient treatment facilities further limits patient access to necessary services. In addition, concerns exist regarding patient isolation, as they are unable to visit family members while in treatment due to fears of spreading the COVID-19 virus.

Third, Montana state administrators noted they are experiencing concerns with limited hospital bed capacity<sup>3</sup> [this problem has increased in severity since the time of this meeting]. Limited capacity also includes the state psychiatric hospital "that is getting full" in Montana.

Fourth, many county jails have suspended in-person programming, including treatment services. Using telehealth to provide treatment services for individuals who are incarcerated has been shown to be successful in these settings.

Finally, since rural states in many cases already have limited and specialized capacity for residential services the PHE has created additional stress to maintain services.

*"On the residential side of things, we are one of two programs in the State of South Dakota that offer residential treatment services for parenting and pregnant women."*

—Amy Hartman, Volunteers of America, Dakotas

## Importance of Communications and Supports

State administrators all emphasized the value of frequent communication with providers during the PHE. The importance of providers having access to updated policy changes, including the revised flexibilities for use of telehealth to deliver services, was underscored in comments.

*"We've been having very, very regular contact with all of our treatment providers about how we can support them, what their needs are, and just talking things through."*

—Melanie Boetel, South Dakota Department of Social Services

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<sup>3</sup> [Hospital bed and capacity in MT](#)

*"We've developed a lot of mechanisms to communicate with our providers to see how we're doing and to adjust things as needed."*

–Brent Kelsey, Utah Department of Substance Abuse and Mental Health

*"We are soliciting input from our providers regarding their desires moving forward, and input from the Tribal communities."*

–Zoe Barnard, Montana Department of Public Health and Human Services

In addition, the importance of working collaboratively with the Medicaid offices has been critical. For example, South Dakota sought guidance on using telephone and videoconferencing services. Montana worked on an 1135 telehealth waiver, as well as solicited input on the use of telephones to deliver treatment services. In Utah and Colorado, Medicaid opened up billing codes to facilitate reimbursement for videoconferencing and telephone counseling on a temporary basis.

Using SAMHSA emergency funds, South Dakota expanded access to videoconferencing equipment, purchased Personal Protective Equipment, increased access to ongoing direct treatment services, and provided additional peer support services. Montana emergency funds provided resources to develop warm lines, offered by a call center, which is a lifeline provider. The SAMHSA/FEMA Crisis Counseling Program in South Dakota expanded crisis counseling through a 605 Program (211 hotline) to connect people to resources impacted by COVID-19 in South Dakota.

*"The state has really stepped up throughout this emergency for behavioral health and taken a considerable amount of the \$1.25 billion that was received for COVID relief and enacted some great programs."*

–Mary Windecker, Behavioral Health Alliance of Montana

The need to support "grassroots recovery community organizations" that are struggling financially was noted as important. One suggestion as a way to offer support included providing space for 12 Step and other types of mutual support meetings. If these organizations are unable to continue post-PHE, the capital needed to rebuild these recovery support resources would be immense.

Finally, an Executive Director of a non-profit agency expressed concern that fundraising opportunities have "dried up" during the PHE. Being unable to raise additional funds due to the limitations of the "philanthropic community" might limit an organization's ability to expand its mission and decrease its growth capacities.

## Telehealth Response: Advantage and Disadvantages

*This theme received extensive discussion, covering both the advantages and disadvantages of virtual service delivery.*

Patient access to technology was identified as a significant barrier as many patients had limited access to computers, tablets, and smart phone this restricting their ability to access services delivered via videoconferencing. However, while most patients had access to mobile phones some had limited call plans which served as a barrier to treatment and recovery support services. Several Board members commented that the PHE increased transparency about inequities relative to access to technology, combined with a host of other inequities. This concern is not just in rural communities, but was also noted by a Denver, Colorado Board member. Efforts to address these concerns have included securing funding for tablets, hot spots, phones with expanded use plans, and other devices. In addition, the use of telephones to deliver intensive outpatient care was noted to be critical in serving Tribal communities in Montana. Likewise, a Utah county recently expanded its Zoom contract to accommodate more users and expand services.

*“All of our outpatient and IOP programs transitioned to telehealth platforms. We’ve heard good things about it, but we’ve also heard that there are people who are being left behind.”*

–Brent Kelsey, Utah Department of Substance Abuse and Mental Health

Several providers noted that patients expressed satisfaction with virtual service delivery and appreciation for all the efforts made by providers to ensure access to services.

*“We’ve done three surveys over the course of the spring and summer months, asking for client input about their treatment experience during the COVID pandemic. Responses were very complimentary of the telehealth individual therapy experience.”*

–Shawn McMillen, First Step House

*“Input from the Tribal communities indicates that release of the telehealth restrictions has been extremely helpful for delivery of intensive outpatient treatment on the reservations.”*

–Zoe Barnard, Montana Department of Public Health, sharing comments with Melissa Higgins from the same agency

The PHE forced adoption and implementation of videoconferencing. Of note, some agency directors indicated that their capacity to offer telehealth services prior to the PHE made the transition easier.



*“Although telehealth has been around for some time, the pandemic has really forced the providers to better adopt the usage, and that has been a real benefit.”*

–Dan Krause, Boyd Andrew Community Services

*“We at Volunteers of America are historically competent with providing telehealth services—for the past six and a half or seven years.”*

–Amy Hartman, Volunteers of America, Dakotas

*“Prior to the pandemic, we developed an initiative to have 30% of our employee’s teleworking, so all staff had laptops and virtual access to our network drives.”*

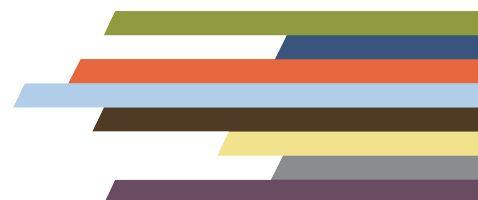
–Brent Kelsey, Utah Department of Substance Abuse and Mental Health

*Concerns identified by Board Members regarding virtual and telephone service delivery included:*

1. Fears that the CMS telehealth waivers created during the PHE might be eliminated, creating concerns about billing and reimbursement;
2. How to best determine patients’ interest in continuing to receive virtual treatment and recovery support services post PHE;
3. Limited access to computers, tablets, and smart phone and bandwidth among patients and peers;
4. Managing different levels of interest in continuing virtual service delivery by clinical and peer support staff post PHE;
5. Questions regarding serving certain patient populations, including youth with serious emotional disturbances;
6. How to maintain/strengthen “organizational commitment” of new employees who have never been on-site; and
7. How to best serve patient and peer populations that only have access to mobile phones.

*“I agree with everyone who is speaking out about the need to maintain audio-only [telemedicine] access for our patients, access to appropriate devices and connectivity. Data plans to support video visits are not equally available.”*

–Lisa Gawenus, Denver Health



*“Very often it’s the case that the individual’s call plan is data limited, so they can’t do certain types of telehealth. The telephone is very important, but for low income people, it can be an access issue.”*

–Shawn McMillen, First Step House

## Opportunities to Re-Examine Delivery of Services

According to Board members, the PHE created opportunities to re-examine how services are delivered and how they may change post PHE. Retention and recruitment issues related to increasing the behavioral health workforce have been examined with some states approving interstate waivers. Many providers, according to Board members that collect data on patient no-show rates, indicate that patient attendance of treatment and recovery support sessions have increased (decrease in no-show rates). In Utah, day treatment programs have shifted to include outreach services, providing meals and medications. These changes in types of service delivery, staffing, origin of service, ancillary services provided in reaction to the PHE may reflect a permanent change according to Board members.

*“What we’ve done now is taught state government that they really don’t need to provide a building for us. So, my bet is that most of us never return to an office environment. I’m going to guess that close to 80% of the division staff will be teleworking in the future.”*

–Brent Kelsey, Utah Department of Substance Abuse and Mental Health

For the Mountain Plains ATTC, the PHE has created opportunities to re-examine how it has adapted its training and technical assistance service. Given the rural and frontier characteristics of the Region, the Mountain Plains has always been innovative in making it easier for providers to access training and technical assistance (TA) through online resources (e.g., webinars, virtual meetings and trainings, etc.). However, with the focus now on maintaining physical distance to avoid the spread of the COVID-19 virus, the Mountain Plains ATTC shifted its entire focus to offering virtual events. For example, hosting large virtual events like the Great Plains Tribal Chairman’s Board, the Third Annual Meth Summit in South Dakota, the Recovery Happens in the Mountain Plains virtual event, and the World Suicide Prevention event are examples of training/TA activities. Likewise, offering webinars, sequenced learning series, and live virtual consultation services not only offer learning opportunities, but also ways for individuals to stay connected with other professionals in the field. Notably, the Mountain Plains ATTC shifted its Leadership Academy to a virtual format finding it afforded many benefits including access to experts and additional mentoring opportunities.

## Summary

The Mountain Plains ATTC Advisory Board meeting provided a venue for Board members to discuss and share their experiences related to the PHE. During the meeting when one Board member spoke others would chime in with comments including “ditto to what [name] just said”. Their shared experiences and mutual appreciation of their colleagues was evident.

*“Of course, we’ve been impacted by COVID, as has everyone else.”*

–Melanie Boetel, South Dakota Department of Social Services

In addition, Board members described both the opportunities and stressors of their work during a global PHE. They noted an increase in anxiety and depression due to Covid-19, which undergirds much of this content.

*“As far as what we’ve seen with COVID, there’s been a lot of anxiety and depression related to isolation.”*

–Karen Severns, Great Plains Area Indian Health Services

An analysis of the Board members’ comments identified six themes. These themes will be used to help guide training/TA services provided by the Mountain Plains ATTC. Most importantly, these themes provided a window into Region 8 stakeholders’ experiences with the PHE and its numerous impacts.

Since the September 2020 meeting, all Region 8 states have experienced a dramatic uptick in cases of COVID-19. North and South Dakota have experienced the most dramatic increase, based on their population, with national attention to this problem in the media and increased worries about access to health care. As such, the Mountain Plains ATTC will continue to check in with its Board members regarding the effects and consequences associated with the PHE and their creative and resourceful responses in light of difficult circumstances while continuing to provide support and training/TA. Finally, these six themes will be shared with the ATTC network (nine regional and two national centers), with the goal of comparing the experiences of the Mountain Plains ATTC Board members with other Regional/National ATTCs as the lessons learned during the PHE may have a lasting impact on SUD treatment and recovery services.